MDR Tracking Number: M5-05-0326-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 9-22-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The therapeutic exercises, manual therapy and office visits on 10-14-03, 11-19-03, 1-26-04, 2-12-04, 3-8-04 and 5-19-04 **were found** to be medically necessary. The electrical stimulation, ultrasound ROM and remainder of the office visits **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

CPT codes 97012, 97140 and 99213 for date of service 6-15-04 were paid in full by the carrier as evidenced by a copy of the check dated 9-13-04. These services will not be a part of this dispute.

CPT code 99455 for date of service 11-19-03 was denied by the carrier with a V for unnecessary medical treatment based on a peer review, however, according to Rule 134.202(e)(6) this exam is not subject to IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Per 133.106(f)(i) **recommend reimbursement of $50.00.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 10-14-03 through 6-2-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 21st day of December, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Date: December 21, 2004

To the Attention Of:
Rosalinda Lopez
TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-0326-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Summary of therapy rendered at ___
- Notes from Dr. E, M.D.
- Designated doctor report from Dr. J, M.D.
- Referrals from Dr. E, M.D.
- Range of motion reports
- Table of disputed services

Submitted by Respondent:

- None

Clinical History

According to the supplied documentation, it appears that the claimant sustained an injury on ___ to her low back while lifting packages at ___. The claimant was first seen at ___. No notes were supplied from the treatment rendered between the date of injury and 10/14/03. On 10/14/03, the claimant consulted with Dr. M, D.C. who became the treating physician. The claimant underwent a facet injection on 10/10/03. The claimant underwent an sacroiliac injection on 10/31/03. Active therapy was begun. On 1/7/04, Dr. E administers a second sacroiliac injection. On 4/16/04, the claimant underwent a right L3-L4, L5-S1 median branch nerve radiofrequency ablation under fluoroscopic guidance and interpretation. The documentation ends here.

Requested Service(s)

Therapeutic procedure, electrical stimulation, manual therapy, ultrasound, office visits, and range of motion for dates of service rendered 10/14/03 thru 6/2/04.

Decision

I disagree with the insurance carrier and agree with the treating provider that the therapeutic exercises (97110) and manual therapy (97140) were considered medically necessary. I also agree with the treating doctor that the office visits dated 10/14/2003, 11/19/2003, 01/26/2004, 2/12/2004, 03/08/2004, and 05/19/2004 were medically necessary. I agree with the carrier that the remainder of care was not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant underwent her first facet injection on 10/10/03 and received seven visits of post injection therapy. On 10/31/03, the claimant underwent an sacroiliac injection and four days later underwent one visit of post injection therapy. Dr. E, the claimant's treating surgeon, prescribed active physical therapy for two weeks on 10/18/03. Following the referral the claimant underwent five visits of physical therapy from 11/19/03 until 12/8/03. After the second sacroiliac injection on 1/7/04, the claimant underwent seven visits of post injection therapy between 1/26/04 thru 3/8/04. Following this date the claimant underwent three more visits of therapy. Therapy rendered in this case is in line with current medical treatment protocols that allow for approximately two weeks of physical/chiropractic therapy following lumbar or sacroiliac injections. Therapy rendered on the dates of service in question should be limited to four units of active therapies which would include the therapeutic exercises (97110) and manual therapy (97140). The additional services rendered on each date of service is not considered reasonable and was not medically supported. Also, daily use of 99213 (evaluation codes) is not seen as reasonable or necessary because the claimant was been seen on a regular basis and the claimant's progress could be easily documented. Monthly office visits are considered reasonable to determine the claimant's improvement or lack thereof by the treating physician of record. The additional therapy rendered in this case appears to be redundant and is not supported by the supplied documentation.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 21st day of December 2004.

Signature of IRO Employee: